### DEPARTMENT OF HUMAN SERVICES

August 1

2015



FATALITY REVIEW EXECUTIVE SUMMARY FY 2015

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### DEPARTMENT OF HUMAN SERVICES FATALITY REVIEW EXECUTIVE SUMMARY

JULY 1, 2014- JUNE 30, 2015

Department of Human Services (DHS) Fatality Review Policy requires a review of the deaths of all individuals for whom there is an open DHS case at the time of death or in cases where the individuals or their families have received services through DHS within 12 months preceding the death. Information obtained from case reviews provides insight into systemic strengths and highlights areas in which changes or modifications could enhance systemic response to client needs.

During FY2015, 270 deaths of current or past DHS clients were reported to the Office of Services Review (OSR). There were 18 suicide deaths (7%) and four homicides (1%). The deaths of 16 individuals (6%) were ruled accidental. The reviews indicate that abuse and/or neglect were contributing factors in four (1%) of the 270 deaths. The Division of Child and Family Services (DCFS) reported three children who died as the direct result of abuse or neglect by their parents, caretakers, or family members. No child died of abuse or neglect while in the custody of DCFS. One individual receiving services through the Division of Services for People with Disabilities (DSPD) died as a result of complications after being scalded in the bathtub.

Of the 37 fatalities reported by DCFS, 37 formal committee reviews were held (100%) with no reviews pending. Thirty-eight of the 71 reported DSPD fatalities were reviewed (53%), 33 reviews were waived (46%), with no reviews pending. Three Division of Juvenile Justice Services (DJJS) fatalities were reviewed (100%). On-site reviews were held for the 10 reported Utah State Developmental Center (USDC) fatalities (100%). Utah State Hospital (USH) conducted on-site reviews for its two reported fatalities (100%).

The deaths of 87 individuals who received services through the Division of Aging and Adult Services (DAAS) were reported. One individual (1%) was receiving services though DSPD and one individual (1%) was receiving services through USDC at the time they received services through DAAS.

The Office of Public Guardian (OPG) reported the deaths of 17 individuals for whom they provided services. Three of these individuals (18%) were also receiving services through DSPD at the time of death, and three individuals (18%) were also receiving services through USDC. Full committee reviews were held for these six individuals. OPG provided the Fatality Review Coordinator with comprehensive written reports detailing services provided by that office and information relating to the deaths of their 17 clients (100%).

The Division of Substance Abuse and Mental Health (DSA/MH) reported the deaths of 47 individuals who were receiving services prior to their deaths or who had received services within twelve months of their deaths. One DSA/MH client (2%) was also receiving services through DJJS; and one individual (2%) was receiving services through DSPD.

There were 130 (48%) reported deaths of male clients and 140 (52%) reported deaths of female clients. Reported deaths included 18 infants (7%) under the age of one year; 31 individuals (11%) between the

ages of one to 19 years; 63 individuals (23%) between the ages of 20 to 49 years; 70 individuals (26%) between the ages of 50 to 69 years; 72 individuals (27%) between the ages of 70 to 89 years, and 16 individuals (6%) between the ages of 90 to 100 years. Included in the 270 reported fatalities were two (1%) Asians, seven Black/African Americans (3%), 238 (89%) Caucasians, sixteen (6%) Hispanics, one Basque, and one individual of unknown ethnicity.

#### DEPARTMENT OF HUMAN SERVICES DIVISION SUMMARY FY 2015

DEPARTMENT/DIVISION	Number of Reported Deaths	Cases Open at Time of Death	Committee Reviews Held	Committee Reviews Waived	Reviews Pending	Female	Male
DEPARTMENT OF HUMAN SERVICES	270	237	102	34	0	140	130
DAAS (Division of Aging and Adult Services)	87	85	N/A	N/A	N/A	49	38
DCFS (Division of Child and Family Services)	37	11	37	0	0	21	16
<b>DJJS</b> (Division of Juvenile Justice Services)	2	2	2	0	0	0	2
DJJS/DSA/MH (Division of Juvenile Justice Services/Division of Substance Abuse/Mental Health)	1	1	1	0	0	0	1
DSA/MH (Division of Substance Abuse and Mental Health)	47	43	N/A	N/A	N/A	30	17
DSPD – COMMUNITIY PLACEMENT (Division of Services for People with Disabilities)	66	65	33	33	0	25	41
DSPD/DAAS (Division of Services for People with Disabilities/Division of Aging and Adult Services)	1	1	1	0	0	0	1
DSPD/DSA/MH (Division of Services for People with Disabilities/Division of Substance Abuse and Mental Health)	1	1	1	0	0	1	0
<b>DSPD/OPG</b> (Division of Services for People with Disabilities/Office of Public Guardian)	3	3	2	1	0	0	3
OPG (Office of Public Guardian)	13	13	13	0	0	8	5
USDC	6	6	6	0	0	5	1

DEPARTMENT/DIVISION	Number of Reported Deaths	Cases Open at Time of Death	Committee Reviews Held	Committee Reviews Waived	Reviews Pending	Female	Male
USDC/DAAS (Utah State Developmental Center/Division of Aging and Adult Services)	1	1	1	0	0	0	1
USDC/OPG (Utah State Developmental Center/Office of Public Guardian)	3	3	3	0	0	1	2
USH (Utah State Hospital)	2	2	2	0	0	0	2

#### CHART I FIVE-YEAR COMPARISON FY 2011 – FY 2015

	FY 2011	FY 2012	FY 2013	FY2014	FY2015
DHS Reported Deaths	207	192	191	214	270
DAAS	36	54	57	73	87
DCFS	52	41	28	35	37
DCFS/DSPD	0	1	1	1	0
DCFS/DSA/MH	1	1		1	0
DJJS	1		1	1	2
DJJS/DCFS	1				0
DJJS/DSA/MH		1			1
DSA/MH	44	15	18	32	47
DSPD	44	59	64	51	66
DSPD/DAAS		2	1	1	1
DSPD/DSA/MH	1		1	2	1
DSPD/OPG	6	1	4	2	3
DSPD/OPG/DSA/MH				1	0
OPG	11	13	11	7	13
USDC	3	3	3		6
USDC/DAAS				1	1
USDC/OPG	6		1	4	3
USH	1	1	1	1	2
USH/DSPD				1	0
Cases Open at Time of Death	157	157	157	173	238
Cases Reviewed	116	109	105	109	103
Abuse & Neglect Deaths	10	11	6	7	4
Accidental Deaths	29	15	9	16	16
Homicides	8	5	2	6	4
Motor Vehicle or Auto/Bicycle/ATV Accidents	11	3	1	5	3
Suicides	10	5	13	7	18
Could Not Be Determined	4	11	4	11	8

## CHART II AGE AT TIME OF DEATH FY 2015

AGE IN YEARS	DHS	DAAS	DCFS	DJJS	DJJS /DSA /MH	DSA /MH	DSPD	DSPD/ DAAS	DSPD /DSA /MH	DSPD /OPG	OPG	USDC	USDC/ DAAS	USDC/ OPG	USH
<1	18		18												
1-3	5		5												
4 - 6	2		2												
7 - 10	4		3				1								
11 - 14	7		4			1	2								
15 - 19	13		5	2	1	3	2								
20 - 29	13					3	10								
30 - 39	25					10	12	1			1				1
40 - 49	25					12	11				1	1			
50 - 59	34	5				9	13		1	2		3		1	
60 - 69	36	14				6	9				3	2	1	1	
70 - 79	32	21				3	4				4				
80 - 89	40	33					2				3			1	1
90 – 100	16	14								1	1				
TOTALS	270	87	37	2	1	47	66	1	1	3	13	6	1	3	2

#### CHART III ACCIDENTAL DEATHS FY 2015

CAUSE OF DEATH	DHS	GENDER	AGE	DIVISION
Asphyxia	4			
Choking		Male	33	DSPD
		Male	62	USDC/DAAS
Compressional		Female	5	DCFS
Positional		Female	52	DSPD
Drowning	2			
		Male	9 months	DCFS
		Male	12	DCFS
Drug Toxicity	5			
		Female	73	DAAS
		Male	19	DSA/MH
		Female	36	DSA.MH
		Female	46	DSA/MH
		Male	51	DSA/MH
Ground-level Fall	1			
		Female	69	DAAS
Smoke Inhalation/House Fire	1			
		Male	91	DAAS
Vehicular Accidents	3			
ATV		Female	9	DCFS
Motor Vehicle		Male	15	DCFS
Motor Vehicle/Bicycle		Male	30	DSPD
TOTAL	16			

#### CHART IV HOMICIDE DEATHS FY 2015

MANNER OF HOMICIDE	DHS	GENDER	AGE	DIVISION
Blunt Force Injuries	2			
		Female	1	DCFS
		Male	2	DCFS
Gunshot Wound	2			
		Male	18	DJJS
		Male	22	DSPD
TOTAL	4			

#### CHART V SUICIDE DEATHS FY 2015

MANNER OF SUICIDE DHS **GENDER AGE** DIVISION Asphyxia (Hanging) 4 **DCFS Female** 14 DSA/MH Female 14 **Female** 16 **DCFS** Male 30 USH **Carbon Monoxide** 1 47 DSA/MH Male **Drug Toxicity** 1 Male 63 DSA/MH **Gunshot Wound** 11 Male 13 **DCFS DCFS** Male 15 DJJS/DSA/MH 16 Male DSA/MH Male 17 DJJS Male 18 **DCFS Female** 19 DSA/MH **Female** 19 Male 22 DSA/MH **Female** 40 DSA/MH DSA/MH Male 44 Male 47 DSA/MH **Train** 1 DSA/MH Male 17 **TOTAL** 18

#### CHART VI ABUSE/NEGLECT DEATHS FY 2015

CAUSE OF DEATH	DHS	GENDER	AGE	DIVISION
Blunt Force Injuries	3			
		Female	1	DCFS
		Female	15 months	DCFS
		Male	2	DCFS
Complications from Scald Wounds	1			
		Male	60	DAAS
TOTAL	4			

# CHART VII MEDICAL EXAMINER'S DETERMINATION MANNER OF DEATH FY 2015

MANNER OF DEATH	DHS	DAAS	DCFS	DJJS	DJJS /DSA /MH	DSA /MH	DSPD	DSPD /DAAS	DSPD /DSA /MH	DSPD /OPG	OPG	USDC	USDC /DAAS	USDC /OPG	USH
Accident	16	3	5			4	2					1	1		
Can Not Be Determined	9		5			3								1	
Homicide	4		2	1		0	1								
Natural Causes	205	84	16			18	62		1	3	13	5		2	1
Pending	18		4			12	1	1							
Suicide	18		5	1	1	10									1
TOTALS	270	87	37	2	1	47	66	1	1	3	13	6	1	3	2

#### CHART VIII DECEDENTS' RACE FY 2015

RACE	DHS	DAAS	DCFS	DJJS	DJJS /DSA /MH	DSA /MH	DSPD	DSPD /DAAS	DSPD /DSA /MH	DSPD /OPG	OPG	USDC	USDC /DAAS	USDC /OPG	USH
ASIAN															
Phillipino	1													1	
Vietnamese	1														
BASQUE	1														
BLACK	7	3	3								1				
CAUCASIAN	238	78	28	1	1	46	60	1	1	2	9	6	1	2	2
HISPANIC	5	4	1												
Latino	1						1								
Mexican	8		3	1		1	2			1					
Panamanian	1										1				
Peruvian	1						1								
PACIFIC ISLANDER															
Hawaiian	2	1	1												
Samoan	1										1				
SPANISH	2	1					1								
UNKNOWN	1		1												
TOTAL	270	87	37	2	1	47	66	1	1	3	13	6	1	3	2

## CHART IX FATALITIES BY DIVISION AND REGION FY 2015

#### **DIVISION OF AGING AND ADULT SERVICES**

REGION	TOTAL
Central	33
Eastern	1
Northern	22
Southeast	9
Southern	12
Southwest	10
TOTAL	87

#### **DIVISION OF CHILD AND FAMILY SERVICES**

REGION	TOTAL
Eastern	3
Northern	13
Salt Lake Valley	11
Southwest	2
Western	8
TOTAL	37

# DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES COMMUNITY BASED and UTAH STATE DEVELOPMENTAL CENTER (USDC)

REGION	TOTAL
COMMUNITY	
PLACEMENT	
Central	42
Northern	17
Southern	1
Western	6
TOTAL	66
USDC	10
TOTAL	76

#### **DIVISION OF JUVENILE JUSTICE SERVICES**

REGION	TOTAL
Region II	2
Region III	1
TOTAL	3

#### **OFFICE OF PUBLIC GUARDIAN**

REGION	TOTAL
Central	
Office of Public Guardian	16
Guardianship Associates	3
TOTAL	19

### DIVISION OF SUBSTANCE ABUSE/MENTAL HEALTH UTAH STATE HOSPITAL

REGION	TOTAL
CENTRAL	3
SOUTHERN	10
WESTERN	34
	47
USH	2
TOTAL	49